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No.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

EPISCOPAL HOSPITAL, ET AL.,

Petitioners,

v.

DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES,

Respondent.

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Nos. 92-5033, 92-5034

EPISCOPAL HOSPITAL, ET AL., APPELLANTS,

v.

DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES, APPELLEES.

Argued March 18, 1993
Decided June 18, 1993

OPINION

Before: EDWARDS, SENTELLE and HENDERSON, Circuit Judges.

SENTELLE, Circuit Judge.

This is an appeal from a District Court judgment upholding the validity of regulations issued by the Secretary of Health and Human Services (the "Secretary") under 42 U.S.C. § 1395ww(d) (1988), which sets forth the methodology for calculating hospitals' Medicare cost reimbursement under the Prospective Payment System ("PPS"). Appellants argue that the Secretary's PPS regulations are based in part on an erroneous interpretation of the enabling statute, or are arbitrary and capricious. The District Court disagreed; we reach the same result and therefore affirm the District Court's judgment.

I. BACKGROUND

A. *Statutory and Regulatory Framework*

Part A of the Medicare Program, 42 U.S.C. § 1395c *et seq.* (1988 & 1991 Supp. III), authorizes payment for primary institutional care, such as hospital services, to eligible aged and disabled

persons. Providers of these services are reimbursed by fiscal intermediaries designated by the provider and the Secretary. 42 U.S.C. § 1395h (1988); 42 C.F.R. § 421.103 (1992). Under Part A, Medicare beneficiaries receive coverage for 90 days of hospital inpatient services in each benefit period, as defined by the statute and regulations, plus an additional 60-day lifetime reserve. 42 U.S.C. § 1395d (1991 Supp. III); 42 U.S.C. § 1395q (1988); 42 C.F.R. § 409.60 *et seq.* (1992).

Until October of 1983, the Medicare Program reimbursed hospitals and other health care providers for the "reasonable cost" of covered services, defined as the "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v) (1988). Under this reasonable-cost regime, hospitals providing inpatient care to Medicare patients received reimbursement for allowable operating costs of services provided to patients, but only to the extent the services were provided on days for which the patients had Medicare coverage. *Id.* § 1395q(d).

Concerned that hospitals had little incentive to reduce or contain costs because reasonable cost reimbursement shifts the burden of cost increases from hospitals to the federal government, Congress enacted provisions in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. No. 97-248, 96 Stat. 324 (1982) (codified at scattered sections of 42 U.S.C.), to address containment of Medicare costs. While the TEFRA provisions left the basic retrospective, cost-based structure of Part A reimbursement undisturbed, it imposed a limit on the rate of increase of Part A reimbursement.

Under TEFRA, the rate-of-increase limit for each hospital was tied to a "target amount." This amount was the hospital's allowable costs of inpatient hospital services for the preceding cost reporting period, increased by a specified percentage in each succeeding cost reporting period. 42 U.S.C. § 1395ww(b)(3)(A) (1988). Though hospitals were subject to reductions in the amount of their Part A reimbursements if their operating costs exceeded the applicable target amounts, *id.* § 1395ww(b)(1)(B), they received bonuses if their operating costs were less than their target amounts. *Id.* § 1395ww(b)(1)(A); 42 C.F.R. § 413.40 (1992).

TEFRA also set out specific exceptions and adjustments to the new limits. Section 1395ww(b)(4)(A) directed the Secretary to

"provide for an exemption from, or an exception and adjustment to, the [rate of increase] method . . . where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. § 1395ww(b)(4)(A). In addition, the subsection authorized the Secretary to "provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate." *Id.; see also* 42 C.F.R. § 413.40(f)-(g) (exemptions and adjustments).

In 1983, Congress replaced the TEFRA-mandated system with a more radical reform of inpatient cost reimbursement, known as the Prospective Payment System. *See* Pub. L. No. 99-272, § 9102, 100 Stat. 155 (1986) (codified as amended, 42 U.S.C. § 1395ww(d) (1988 & 1991 Supp. III)); 42 C.F.R. § 412.1 *et seq.* (1992). Under this system, hospitals and other health care providers are reimbursed on the basis of prospectively determined national and regional rates, rather than reasonable operating costs. The system classifies Medicare patients into one of approximately 470 "diagnosis related groups" ("DRGs") based on differences in patients' utilization of hospital resources by groups and establishes fixed rates for each. The PPS rates do not vary according to the actual costs of individual cases, but are designed to allow efficient providers to recover their average costs of serving Medicare patients during a cost reporting period.

In enacting the PPS, Congress simultaneously provided for various exceptions and adjustments, as it had when it enacted TEFRA's rate-of-increase limit. Section 1395ww(d)(5) directs the Secretary to implement specific exceptions and adjustments, 42 U.S.C. § 1395ww(d)(5)(A)-(H), and to provide by regulation for other exceptions and adjustments to payment amounts "as the Secretary deems appropriate." *Id.* § 1395ww(d)(5)(I). In contrast to the analogous provision in TEFRA, however, § 1395ww(d)(5)(I) does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period.

Though eager to restrain health care costs, Congress recognized that immediate institution of the PPS could pose financial hardship for many health care providers. It therefore created a four-year transition period between the reasonable cost system and the PPS, 42 U.S.C. § 1395ww(d), designed to "minimize disruptions

that might otherwise occur because of a sudden change in reimbursement policy." H.R. REP. No. 25, 136, 98th Cong., 1st Sess., *reprinted in* 1983 U.S.C.C.A.N. 355.

During the transition period, the government was required to reimburse hospitals for inpatient hospital services according to a "blended" rate, based upon two components. The first was the hospital-specific portion ("HSP"), defined as a hospital's "allowable operating costs of inpatient hospital services" in a prior base year, *i.e.*, the Medicare cost year ending on or after September 30, 1982. 42 U.S.C. § 1395ww(b)(3)(A). The HSP is a percentage of the hospital's target amount as defined in subsection (b)(3)(A). The second element was the "federal" portion, a computation from regional and national DRG rates approaching the PPS rate. 42 U.S.C. § 1395ww(d)(2)(A), (B). Over the course of the four-year transition period, the portion of the reimbursement amount attributable to the prospective rate became progressively larger and HSP progressively smaller, until the prospective rate formed the exclusive basis for PPS reimbursement at the end of the transition period. *Id.* § 1395ww(d)(1)(C).

In implementing the PPS, the Secretary promulgated regulations modifying prior Medicare coverage rules. *See* 48 Fed. Reg. 39,752 (1984) (codifed at 42 C.F.R. § 405 *et seq.* (1992)). Inpatient hospital stays involving at least one day of Medicare eligibility would be treated as fully "covered" stays under Part A, for which the PPS payment itself would represent payment in full, regardless of the length of stay or extra costs attending the patient's recovery. 42 C.F.R. § 412.2(b)(2) (1992) (formerly 42 C.F.R. § 405.70(b)(2)(ii) (1984)). Because hospitals were prohibited from billing costs not fully reimbursed by Medicare, *id.* § 412.42(a), the "balance," in effect, was no longer reimbursable.

B. *Facts*

Appellants in this case are seven short-term acute care hospitals providing inpatient care under the Medicare program. Through their fiscal year ending June 30, 1984, appellants received reimbursement under the reasonable cost system. During the transition years, their PPS rates, including the HSP, were calculated by their intermediaries before the start of their first year under the PPS and were annually updated and used to determine their PPS payments per discharge. Excluded from the base-year costs were

costs associated with care furnished to Medicare beneficiaries for hospitalization after their Medicare coverage had been exhausted, costs for which Medicare had reimbursed the hospitals under the reasonable cost system. The hospitals sought an adjustment from their intermediaries to include these costs in the base-year totals, for purposes of calculating the HSP of their PPS rates. The intermediaries declined to adjust the costs because the Secretary's regulations did not provide for such an adjustment. The hospitals appealed to the Provider Reimbursement Review Board, which, on April 12, 1989, certified the issue for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f) (1988).

The hospitals then filed the present action in the United States District Court on June 15, 1989, requesting an order compelling the Secretary to compensate them for costs that were improperly excluded from the hospital-specific portions of their transition-year payment rates. On cross-motions for summary judgment, the District Court reviewed the record and concluded that the Secretary had acted lawfully in not providing for adjustments to hospitals' base-year costs to reflect costs associated with care furnished to patients after their Medicare coverage had been exhausted. *Episcopal Hosp. v. Sullivan*, Medicare & Medicaid Guide, (CCH) ¶ 39,817 (D.D.C. 1991). The court assumed, without discussion, that 42 U.S.C. § 1395ww(b)(4)(A), which authorizes the Secretary to make adjustments in "extraordinary circumstances," applies to transition rates under PPS. However, the court upheld as based on a permissible reading of the statute the Secretary's conclusion that promulgation of a new regulation treating exhausted stays differently than under reasonable cost reimbursement was not an event "beyond the hospital's control or extraordinary circumstances" within the meaning of § 1395ww(b)(4)(A). The court also concluded that the Secretary did not abuse her discretion under § 1395ww(d)(5)(D) to provide the adjustment the hospitals sought.

This appeal followed.

II. Discussion

Appellants argue in the first instance that the plain meaning of the enabling statute required the Secretary to make adjustments they seek. In the alternative, they argue that even if the statute

does not require the Secretary to make the requested adjustments, the Secretary's refusal to make the base-year adjustments was arbitrary and capricious.

Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), provides the proper framework for the statutory interpretation issue. That case held that

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. . . . [However,] if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-43.

Appellants rely on § 1395ww(b)(4)(A), which states that "[t]he Secretary shall provide for an exemption from, or an exemption and adjustment to, the [statutory rate of increase] method . . . where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period." 42 U.S.C. § 1395ww(b)(4)(A). They note that § 1395ww(d)(1)(A)(i)(I) incorporates by reference the TEFRA "target rate" definition of subsection (b)(3), for purposes of setting the PPS base-period, hospital-specific costs. Subsection 1395ww(b)(3), they argue, is in turn subject to the provisions of subsection 1395ww(b)(4)(A), which requires the Secretary to make adjustments to the target rate in "extraordinary circumstances." *Id.* § 1395ww(b)(4)(A). Thus, appellants conclude that § 1395ww(d)(1) explicitly incorporates subsection (4)(A)'s extraordinary-circumstances mandate.

We do not agree. Section 1395ww(b)(3)(A), defining "target amount," plainly does *not* incorporate subsection (b)(4)(A). In fact, section 1395ww(b)(3)(A) never mentions that subsection, although it does refer to other exceptions from the target amount method determined under subparagraph (b)(3)(A). *See* 42 U.S.C. § 1395ww(b)(3)(A). Nor does subsection (b)(4)(A) either define "target amount" or modify the definition set forth in (b)(3)(A). In fact, subsection (b)(4)(A) explicitly authorizes the Secretary to depart from the "target amount" benchmark in (b)(3)(A) in specific circumstances, suggesting that incorporation of (b)(4)(A)

might conflict with the congressional intent partially to base reimbursement on the target amount during the PPS transition period. Certainly, the fact that Congress clearly incorporated subsection (b)(3)(A), while never referring to subsection (b)(4)(A), suggests that when Congress intended to incorporate a TEFRA provision into PPS, it did so expressly and that it did not intend to incorporate the provision at issue here.

Furthermore, appellants are unable to reconcile their argument with § 1395ww(d)(5). That section mandates specific adjustments and exceptions to the amount a hospital may be reimbursed for its inpatient operating costs under the PPS, *see* § 1395ww(d)(5)(A)-(H), and gives the Secretary general authority to provide for other exceptions and adjustments "as the Secretary deems appropriate." *Id.* § 1395ww(d)(5)(I). The quoted language also appears in subsection (b)(4)(A); significantly, however, subsection (d)(5) contrasts with subsection (b)(4)(A), insofar as the former does not include a provision for upward modification of a hospital's target rate in "extraordinary circumstances." *Compare* 42 U.S.C. § 1395ww(d)(5)(I) *with id.* § 1395ww(b)(4)(A).

In light of the foregoing, not only are we unable to agree with appellants that the statute requires the Secretary to make the requested adjustments, but it appears that the meaning may be quite the contrary. Even if we admit the possibility of other interpretations, appellants still do not prevail. Under the second step of *Chevron*, we "need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Chevron*, 467 U.S. at 843 n.11. We need only determine "whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. In short, to the extent that the statute is ambiguous, the Secretary's interpretation, which is a permissible one for the reasons given above, must be upheld.

Having upheld the Secretary's reading of the statute under the *Chevron* analysis, we turn to appellants' second argument, that the Secretary's promulgation and application of the implementing regulations was arbitrary and capricious.

The appropriate standard for reviewing the Secretary's exercise of the discretion afforded under the statute is dictated by 42

U.S.C. § 1395oo(f)(1), which incorporates the Administrative Procedure Act ("APA"), 5 U.S.C. § 706(2)(A) (1988). Under the APA, we hold unlawful and set aside only those agency actions that we find "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." *Id.* Insofar as the question of whether the Secretary's regulations are in accordance with law, it follows from our analysis above the Secretary acted consistently with the statutory mandate, and in furtherance of the congressional goals.

As to the argued arbitrariness or capriciousness of the form she chose for doing so, we have often made it plain that we do not sit to interfere with the policy decisions of an agency, *Ethyl Corp. v. EPA*, 541 F.2d 1, 34 (D.C. Cir.) (en banc), *cert. denied*, 426 U.S. 941 (1976) (noting that this Court is "forbidden from substituting [our] judgment for that of the agency"), and we will not do so here. A review of the Secretary's official explanation of the final rules, 49 Fed. Reg. 234, 246-49 (1984), reveals that the Secretary responded to the comments that were in fact submitted. She revealed her goals and reasoning. She gave us a record which "will enable us to see what major issues of policy were ventilated by the . . . proceedings and why the agency reacted to them as it did." *Walter O. Boswell Mem. Hosp. v. Heckler*, 749 F.2d 788, 794 (D.C. Cir. 1984) (internal quotation marks omitted). She did, in short, all that the APA required.

We note that the root cause of appellants' objection to the PPS implementing regulations lies not in the refusal of adjustments, but rather in 42 C.F.R. § 412.42(a), which prohibits hospitals from charging Medicare patients whose bills exceed the amount paid to the hospital under the PPS. That regulation reads as follows:

> A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's cost of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems.

Id. Obviously, this regulation may prevent health care providers from recouping losses which they may sustain when a Medicare patient remains with them beyond the average stay per ailment or requires greater than average care. There is, however, nothing we can do for appellants in this regard as they have not challenged § 412.42(a), but only the Secretary's discretionary refusal to

adjust the base-year computations to offset the effect of the change in regulations. *See Association of Accredited Cosmetology Schools v. Alexander*, 979 F.2d 859, 862 (D.C. Cir. 1992) (courts ordinarily do not address new legal theories on appeal).

III. Conclusion

For the reasons set forth above, we hold that the plain language of the PPS statute and its implementing regulations support the Secretary's contention that the PPS does not include an "emergency circumstances" provision. Further, the Secretary's implementation of the statute was neither arbitrary, capricious, nor unlawful. Therefore, the judgment of the District Court is hereby

Affirmed.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Nos. 92-5033, 92-5034

EPISCOPAL HOSPITAL, ET AL., APPELLANTS,

v.

DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES, APPELLEES.

Argued March 18, 1993
Decided June 18, 1993

JUDGMENT

Before: EDWARDS, SENTELLE and HENDERSON, Circuit Judges.

These causes came on to be heard on the record on appeal from the United States District Court for the District of Columbia and were argued by counsel. On consideration thereof, it is

ORDERED and **ADJUDGED,** by the Court, that the judgment of the District Court appealed from in these causes is hereby affirmed, in accordance with the Opinion for the Court filed herein this date.

Per Curiam
FOR THE COURT:
RON GARVIN, CLERK

BY: /s/ ROBERT A. BONNER

Robert A. Bonner
Deputy Clerk

Date: June 18, 1993

Opinion for the Court filed by Circuit Judge Sentelle.

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CIVIL ACTION NO. 89-1716

EPISCOPAL HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

November 12, 1991

MEMORANDUM OPINION

JOHNSON, District Judge.

Plaintiffs are seven short-term acute care nonprofit hospitals which participate in the Medicare program. They challenge as arbitrary and capricious a refusal by the Secretary of Health and Human Services ("the Secretary") to adjust the hospital-specific portion of their payment rates during the transition period from the "reasonable cost" Medicare payment system to the current "prospective payment system" ("PPS"). Plaintiffs claim that they are entitled to an upward adjustment of these payment rates because of a change in the Secretary's regulation governing Medicare coverage of hospital stays consisting in part of non-payable Medicare days. Pending before the Court are the parties' cross-motions for summary judgment. There are no disputes of material fact. For the reasons outlined below, the Court will grant defendant's motion for summary judgment and deny plaintiffs' motion for summary judgment.

BACKGROUND

A. *General Statutory Background*

Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc (1988), commonly known as "Medicare," was created by

the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 291. It is a nationwide health insurance program primarily for people who are aged sixty-five and over, and it is available to covered beneficiaries without regard to income or wealth.

Until 1983, the Medicare program paid for hospital care on a retrospective, "reasonable cost" basis. At the end of each fiscal year, a hospital provider would file with its "fiscal intermediary" a report indicating the total costs for which the provider sought Medicare reimbursement. The fiscal intermediary, who was bound by the Secretary's regulations and by Manual instructions issued by the Health Care Financing Administration (HCFA), would audit the report and issue a Notice of Program Reimbursement, indicating which of the provider's costs would be considered "allowable," and thus reimbursable, under Medicare.

Because the reasonable cost reimbursement system offered hospitals little incentive to keep their costs down, Congress set about to change Medicare's system of reimbursement. In April 1983, Congress enacted a new Medicare reimbursement scheme called the Prospective Payment System ("PPS"). Rather than reimbursing hospitals for the actual costs of providing services, PPS reimburses providers on the basis of a predetermined fixed rate for each discharge covered by Medicare; the fixed rate is a multiple of a flat payment rate and a weighting factor that is based upon the particular patient's "diagnosis-related group" ("DRG"). Each DRG weight represents the average resources required to care for cases in a particular DRG relative to the national average resources consumed per case by the average hospital. Thus, cases in a DRG with a weight of 2.0 would, on average, require twice as many resources as the average case for the average hospital. Generally, the hospital would receive this amount for the discharge, regardless of the individual services actually furnished or the number of days of care.

PPS was "intended to improve the Medicare program's ability to act as a prudent purchaser of services, and to provide predictability regarding payment amounts for both the Government and hospitals." H.R. Rep. No. 25, 98th Cong., 1st Sess., at 132 (1983). In order to "minimize the disruptions that might otherwise occur because of a sudden change in reimbursement policy," *id.* at 136, Congress decided to provide for a "phase-in" period of

four years, starting with the hospital's first accounting year beginning on or after October 1, 1983.[1] During this transition period, PPS payments were based upon a blend of a hospital's "target amount" (referred to in regulations as the "hospital-specific portion" or "HSP") and a federal amount (the "DRG prospective payment rate"). 42 U.S.C. § 1395ww(d)(1)(A). The hospital-specific portion of this blended rate was to be derived from each hospital's actual operating costs during a designated "base year."

During the first transition year, the hospital-specific rate comprised 75% of the blended payment rate, and the federal portion, 25%. In the second year, the ratio was 50% for each portion. In the third year, the hospital-specific portion comprised 45%, and the federal portion 55% of the PPS transition payment; and in the fourth year, the ratio was 25% hospital-specific and 75% federal. Thereafter, the payment rate was based entirely on the federal rate calculated under PPS, as described above. Thus, until the Medicare reimbursement system no longer depended on some proportion of the hospital-specific cost base — in other words, until the PPS system was completely phased in after the fourth transition year — the amount of reimbursement which a hospital would receive from Medicare depended in part upon the precise calculation of its "allowable costs" for the base year. For the reporting periods between 1982 and 1987, HCFA's determination of what was and was not included in the hospital's cost base had a significant impact on the amount hospitals were reimbursed during the transition period.

Congress recognized that adjustments and modifications to the base year costs might be necessary. It required the Secretary to update the costs for inflation, 42 U.S.C. § 1395ww(d)(2)(B), and it gave the Secretary the authority to provide for exceptions and adjustments to "take into account the special needs" of regional and national referral centers and sole community hospitals. 42 U.S.C. § 1395ww(d)(5)(C). Congress also required the Secretary to provide for exceptions and adjustments "where events beyond the hospital's control or extraordinary circumstances" created a

1. Congress originally intended the phase-in period to last for three years, but in 1986 the period was extended by one more year. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9102(a), 100 Stat. 82, 155 (1986).

distortion in the increase in the hospital's costs. 42 U.S.C. § 1395ww(b)(4)(A).

B. *The Regulations at Issue in This Case*

In September 1983, the Secretary promulgated a series of regulations designed to implement Section 1886(d) of the Medicare Act, which established the new prospective payment system. 42 C.F.R. § 405.470(b)(2), which was redesignated in April 1985 as § 412.2(b)(2), provides that "the full prospective payment amount, as determined under subpart D, E, or G of this part, is made for each stay during which there is at least one Medicare payable day of care." 42 C.F.R. § 412.2(b)(2) (1990). Thus, under § 412.2(b)(2), a hospital will be reimbursed equally for Medicare beneficiaries whose Medicare coverage is not exhausted during their hospital stay and for those Medicare beneficiaries whose coverage *is* exhausted during their stay; in other words, the prospective payment system, which reimburses hospitals on a per discharge basis, treats as equals patients who have enough remaining Medicare payable days to cover their *entire* hospital stay, and those whose remaining Medicare payable days cover as little as *one* day of their entire hospital stay. Under the previous reasonable cost reimbursement system, Medicare reimbursed a hospital only for a patient's Medicare payable days; if the patient exhausted his Medicare payable days during his stay in the hospital, the hospital would have to seek payment either from the patient himself, or from a Medigap insurer to make up the difference. Through § 412.2(b)(2), then, Medicare coverage after the implementation of PPS, and during the transition period to PPS, suddenly included hospital stays which consisted in part of non-payable Medicare days ("exhausted stays"). This had not been the case under the old Medicare system.

Plaintiffs in this case are seven short-term acute care nonprofit hospitals. Their base year for purposes of calculating the hospital-specific portion of their transition payment rates was July 1, 1982 through June 30, 1983. Plaintiffs claim that, because § 412.2(b)(2) was not promulgated until after the hospitals' base year costs had been calculated, there is an inherent cost disparity between the costs which they actually incurred during the transition period, and the hospital-specific portion of their payment rates throughout the transition period. Since the hospital-specific portion of their transition payment rates was based upon their base year

costs, and since exhausted stays were not included in these base year costs, plaintiffs argue that the hospital-specific portion of the transition payment rates was unfairly "diluted." They seek recalculation of their base year costs to include costs incurred during exhausted stays. Plaintiffs insist that it is only through such a recalculation, and its application to HSP rates throughout the transition period, that they will be fairly reimbursed in a manner consistent with Congress' intent.

Discussion

A. *The Appropriate Standard of Review*

The appropriate standard of review is set out at 42 U.S.C. § 1395oo(f)(1), which incorporates the Administrative Procedure Act ("APA") at 5 U.S.C. § 706(2)(A). That standard requires the Court to "hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." Thus, the issue before this Court is whether the Secretary's refusal to apply § 412.2(b)(2) to adjust plaintiffs' base year costs is not in accordance with the statutory mandate of 42 U.S.C. §§ 1395ww(b)(4)(A) and (d)(5)(I).

In reviewing an agency's construction of a statute, a court must first determine "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984); *see also Georgetown Univ. Hosp. v. Bowen*, 862 F.2d 323, 326 (D.C. Cir. 1987). Where the statute and the intent behind it are ambiguous with respect to a matter at issue, however, the Court must decide whether the agency's construction of the statute is "based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843. The Court may not substitute its own construction of a statutory provision if the agency's interpretation is "reasonable." *Id.* at 844.

B. *Statutory Language and Legislative History*

Plaintiffs claim that the Secretary's refusal to adjust their base year costs violates 42 U.S.C. § 1395ww(b)(4)(A) and 42 U.S.C. § 1395ww(d)(5)(I). Both of these provisions delineate the authority of the Secretary to provide for adjustments to hospitals' base

year costs. The Court will consider each statutory provision in turn.

1. 42 U.S.C. § 1395ww(b)(4)(A)

42 U.S.C. § 1395ww(b)(4)(A) states:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). . . .

42 U.S.C. § 1395ww(b)(4)(A) (1988). According to plaintiffs, the statute's use of the word "shall" makes this provision mandatory: if the Secretary finds that an "event beyond the hospital's control" or "extraordinary circumstance" has created a distortion in the hospital's costs, the Secretary *must* provide for an adjustment. Both the plain reading of the word "shall" and the legislative history of this provision comport with plaintiffs' understanding. The dictionary defines "shall" as a word "used in laws, regulations, or directives to express what is mandatory." *Webster's Third New International Dictionary* 2085 (1961). Moreover, Congress indicated that, under this provision, "[t]he Secretary of HHS would be *required* to provide for appropriate exemptions, exceptions, and adjustments. . . ." H.R. Conf. Rep. No. 760, 97th Cong., 2d Sess. at 420 (1982) (emphasis added). *See also Sacred Heart Medical Center v. Sullivan*, Nos. 89-7004, 90-6659, 90-7131, 1991 WL 129834, at *5 (E.D. Pa. July 11, 1991). Thus, it is clear from the language and legislative history of the statute that this provision is a mandatory directive to the Secretary.

The question remains, however, whether the Secretary's promulgation of a new regulation which treats exhausted stays differently is an "event beyond the hospital's control or extraordinary circumstance" within the meaning of this subsection. The phrase itself is certainly ambiguous, and surrounding language offers little indication of what Congress meant by an "event beyond the hospital's control or extraordinary circumstances." The only example cited in the section is "changes in the case mix" of the hospital.

Although the legislative history of § 1395ww(b)(4)(A) does not explicitly exclude subsequent changes in agency regulations from the definition of "events beyond the hospital's control or extraordinary circumstances," it does suggest that Congress did not contemplate such a definition. In considering what types of situations would require adjustments under § 1395ww(b)(4)(A) and (d)(5)(I), Congress focused on changes in the nature of services provided, changes in the composition of patients served, and particular difficulties encountered by hospitals located in geographically isolated areas. The Senate committee's discussion of the types of adjustments it envisioned echoes other Congressional committee reports on these provisions:

> The Secretary would be required to provide for exceptions and adjustments to take into account the special circumstances faced by sole community providers. . . .
>
> The committee . . . expects that the Secretary, in making such determinations for sole community providers under the new prospective payment system, will develop and take into account a much broader range of factors relating to beneficiary access to basic hospital services. . . .
>
> Under this amendment, the Secretary would also be required to provide exceptions and adjustments, as he deems appropriate, to take into account the special needs of public or other hospitals that serve a disproportionately large number of low-income and part A Medicare beneficiaries. . . .
>
> Exceptions and adjustments would also be permitted to take into account the special needs of hospitals located in Alaska and Hawaii, as the Secretary now does in applying the reimbursement limits of present law.

S. Rep. 23, 98th Cong., 1st Sess., at 54 (1983); *see also* H. Rep. 25, 98th Cong., 1st Sess., at 154-55 (1983); H. Rep. 760, 97th Cong., 2d Sess., at 420 (1982) (conference report on Tax Equity and Fiscal Responsibility Act). Nowhere in the legislative history of § 1395ww(b)(4)(A) does Congress address the possible interpretation plaintiffs are urging — that the Secretary's promulgation of a regulation which changes the calculation of Medicare reimbursement is sufficient grounds for an adjustment to a hospital's base year costs. Furthermore, the kinds of adjustments that various courts have required the Secretary to make under § 1395ww(b)(4)(A) do not include adjustments based on regulatory changes. Generally, adjustments to base year costs under

this subsection have been mandated only in the context of hospital construction or renovation that occurred after the base year. *See, e.g., Sacred Heart Medical Center v. Sullivan*, 1991 WL 129834 (E.D. Pa. 1991) (court required adjustment under § 1395ww(b)(4)(A) where hospital's base year costs did not reflect new additional facility that had opened after calculation of its base year costs); *Newport Hospital and Clinic, Inc. v. Sullivan*, No. 88-1490, 1990 WL 179953 (D.D.C. 1990) (hospital which undertook construction would be allowed to have its Medicare hospital-specific rates retroactively adjusted because this was "extraordinary circumstance" contemplated by statute). Thus, the Court must conclude that, at the very least, it is unclear from the language of the statute and its legislative history whether Congress intended the Secretary to make the kinds of adjustments plaintiffs demand under § 1395ww(b)(4)(A). The Court's review of the Secretary's refusal to make the adjustments will therefore be limited to a determination of whether this refusal was reasonable.

2. *42 U.S.C. § 1395ww(d)(5)(I)*

Section 1395ww(d)(5)(I) is a catch-all provision for adjustments that delegates decision-making authority to the Secretary: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." 42 U.S.C. § 1395ww(d)(5)(I) (1988). Plaintiffs' reliance on this provision to demonstrate a statutory mandate directing the Secretary to make certain adjustments is entirely misplaced. By its very terms, § 1395ww(d)(5)(I) leaves the decision of whether or not to grant an adjustment in the Secretary's hands; he need only make those exceptions that he "deems appropriate." Thus, as to this statutory provision as well, the Court's review will be limited to the question of whether the Secretary's exercise of discretion was reasonable.

C. *The Secretary's Refusal to Adjust Plaintiffs' Base Year Costs*

The Secretary argues that § 1395ww(b)(3)(A) directs him to calculate the hospital-specific portion of reimbursement rates during the transition period to PPS on the basis of "allowable operating costs of in-patient hospital services . . . recognized under this title for such hospital for the preceding 12-month cost

reporting period. . . ." 42 U.S.C. § 1395ww(b)(3)(A) (1988). In other words, the Secretary claims he is limited, in calculating the base year costs, and any adjustment to those costs, by the term "allowable costs": only if a cost is "allowable" can the Secretary include it in the base year. The Secretary further argues that the term "allowable costs" refers exclusively to those costs that would have been reimbursed under the old "reasonable cost" Medicare system. Because under the reasonable cost system Medicare did not cover hospital stays where beneficiaries' days of covered services were exhausted, the Secretary concludes that those kinds of costs are simply not "allowable," notwithstanding any subsequent change in regulatory policy.

The broader issue here is whether the hospital-specific portion of hospitals' transition period payments is retrospective or prospective. Plaintiffs argue that it is prospective: Congress included the hospital-specific portion to ease hospitals' transition to the new payment system, and allowed adjustments to hospitals' base years to ensure that the hospital-specific rate would more closely reflect costs that would be paid under the prospective payment system. The Secretary insists that the hospital-specific portion must be retrospective because it is based on hospitals' *historical* costs, not their projected costs under the new system. Under this retrospective interpretation, adjustments serve the purpose of correcting mistaken calculations as to what was and was not considered "allowable" under the reasonable cost system.

Although the Court does not agree that *all* adjustments to hospitals' base year costs must be limited to "allowable costs," the Court does find that the adjustments sought in this case must be limited to "allowable costs." This Circuit has recently had occasion to consider the interpretation of "allowable costs" under § 1395ww(b)(3)(A) and how that phrase affects adjustments to hospitals' base year costs. In *Georgetown Univ. Hosp. v. Bowen*, 862 F.2d 323 (D.C. Cir. 1988), the Court of Appeals examined the language and legislative history of § 1395ww(b)(3)(A) to determine that "allowable" does refer back to the reasonable cost system:

> In the most direct language, therefore, Congress clearly ordered that costs that were 'allowable' under the old system were to remain a component of payment rates during the phase-in period of the new system. 'Allowable,' in turn, invokes a straightforward concept: if

> the reasonable cost system would have reimbursed a hospital for a given cost, it was 'allowable' and should become a factor in determining a hospital's base year figure.

Georgetown v. Bowen, 862 F.2d at 326. Moreover, the Court of Appeals concluded that Congress, by including a hospital-specific portion in the transition period payment, "signalled an intent to keep certain elements of the former system in place at least temporarily — elements that would in the end be abandoned altogether, but which were nevertheless included in order to minimize financial disruptions." *Id.* at 327. Thus, this Circuit has interpreted the hospital-specific portion as retrospective rather than prospective.

However, the Secretary's argument that *all* adjustments to a hospital's base year costs must be limited to those costs that were "allowable" under the reasonable cost system cannot succeed. Generally, adjustments to hospitals' base year costs do involve an interpretation of whether the cost would or should have been "allowable" under the reasonable cost system. *See, e.g., St. Mary of Nazareth Hosp. Center v. Heckler*, 760 F.2d 1311 (D.C. Cir. 1985) (labor/delivery room days improperly excluded from allowable cost calculation); *Samaritan Health Serv. v. Bowen*, 811 F.2d 1524 (D.C. Cir. 1987) (sick newborn facility improperly excluded from reimbursement under reasonable cost system). But the language of the statute itself, as well as its legislative history, indicates that Congress intended some costs to be included in a hospital's base year which had not been included under the reasonable cost system. The clearest example of such a cost, and one upon which plaintiffs heavily rely, are FICA taxes. Under the reasonable cost system, Medicare hospitals did not have to pay such taxes; under the prospective payment system, they are required to pay them. Thus, Congress explicitly provided, in 42 U.S.C. § 1395ww(b)(6), for an adjustment to hospitals' base year costs based upon an estimate of FICA tax costs. 42 U.S.C. § 1395ww(b)(6) (1988); *see also* H.R. Conf. Rep. 47, 98th Cong., 1st Sess., at 181-82 (1983) ("The managers recognize that, in some cases, the Secretary will have to use estimates to adjust some portions of the hospital's base year experience to make it comparable to inpatient operating costs that will be paid under the prospective system — e.g. FICA taxes . . .").

Significantly, those cost adjustments, such as the ones for FICA taxes, that do not fall in the "allowable cost" category are separately provided for in the statute, *see, e.g.*, 42 U.S.C. § 1395ww(b)(4)(A) (adjustments required for "events beyond the hospital's control or extraordinary circumstances"); 42 U.S.C. § 1395ww(b)(6) (FICA adjustments); 42 U.S.C. § 1395ww(d)(5)(E)(i) (adjustments for costs of ancillary services previously categorized under Part B of Medicare). The cost adjustments sought here have already been determined not to fall within § 1395ww(b)(4)(A), and it is clear they do not fall within the FICA or ancillary services provisions. Thus, the Secretary was not unreasonable in considering plaintiffs' request for adjustments under the framework of "allowable costs."

Finally, in determining whether the Secretary acted reasonably in this case, the Court considers the following chronology: Plaintiffs' base year was July 1, 1982 through June 30, 1983. The regulation which redefined exhausted stays under Medicare, 42 C.F.R. § 412.2(b)(2), was first promulgated through an interim final rule with comment issued on September 1, 1983, and then through the final rule published on January 1, 1984. Plaintiffs' entire base year thus preceded the issuance of § 412.2(b)(2). In order to increase the hospital-specific portion of plaintiffs' transition payments during the years 1985 through 1988, the Secretary would have to apply § 412.2(b)(2) *retroactively* to recalculate plaintiffs' base year costs. The Supreme Court has made it very clear in *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988), that, in the absence of express statutory authority, the Secretary may not promulgate rules with retroactive effect. *Bowen*, 488 U.S. at 208. The Supreme Court did not find such express statutory authority for cost limit rules under the Medicare Act in *Bowen;* nor does such express authority exist for the rules promulgated under §§ 1395ww(b) or (d). Moreover, it is difficult for this Court to believe that Congress intended to allow the Secretary to promulgate regulations which would retroactively increase or decrease allowable costs in hospitals' base years.[2]

2. Were this Court to agree that § 412.2(b)(2) should be applied retroactively, it would essentially be giving the Secretary the authority to promulgate other rules that might increase or *decrease* hospitals' base year calculations. The Court suspects that plaintiffs would not be making the same arguments, had the Secretary promulgated and retroactively applied a regulation in late 1983 which would have *decreased* plaintiffs' base year costs.

Plaintiffs claim that they are merely seeking retroactive case-by-case cost adjustments and not retroactive application of a rule. They rely on *Bowen*'s statement that the Medicare Act allows "case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases." *Bowen*, 488 U.S. at 209. However, plaintiffs are not arguing in this case that § 412.2(b)(2) was misapplied in their cases they are arguing that the regulation was not applied at all when it should have been. Moreover, plaintiffs cannot limit the application of § 412.2(b)(2) to their own case; if § 412.2(b)(2) requires recalculation of plaintiffs' base year costs, it requires recalculation of the base year costs of *every* hospital which did not get Medicare reimbursement for exhausted stays in its base year. Had the Secretary done what plaintiffs are seeking in this action, he would have had to apply his rule retroactively, in violation of the Supreme Court's mandate in *Bowen*. The Court cannot find that his refusal to do so was unreasonable.

D. *Equal Protection and Substantive Due Process Claims*

Plaintiffs' final claim is that the Secretary' approach to granting adjustments violates principles of equal protection and substantive due process embodied in the Due Process Clause of the Fifth Amendment. Plaintiffs argue that, by granting adjustments for FICA taxes and anciliary hospital services but refusing the adjustments sought here, the Secretary purposefully and arbitrarily sought to benefit certain classes of hospitals and disadvantage others. This claim has no merit. The FICA and ancillary services adjustments cited by plaintiffs were specifically mandated by Congress. *See* 42 U.S.C. § 1395ww(b)(6) and § 1395ww(d)(5)(E)(i). As discussed above, Congress gave the Secretary the discretion to grant or deny other adjustments not specifically mandated. The Court has determined that the Secretary exercised this discretion reasonably, in a manner rationally designed to achieve the legitimate governmental purposes set out in the Medicare Act. *California v. Aznavorian*, 439 U.S. 170, 174 (1978). Thus, the Secretary's approach does not violate constitutional principles of equal protection and substantive due process.

CONCLUSION

Nothing in the Medicare Act or its legislative history indicates that Congress intended the Secretary to make adjustments to hospitals' base year costs when subsequent regulations redefine Medicare coverage. After reviewing the Secretary's refusal to allow such adjustments, the Court concludes that his action was reasonable. Thus, the Court hereby denies plaintiffs' motion for summary judgment and grants defendant's motion for summary judgment. An order consistent with this Memorandum Opinion will be entered this day.

/s/ NORMA HOLLOWAY JOHNSON

NORMA HOLLOWAY JOHNSON
UNITED STATES DISTRICT JUDGE

Dated: November 12, 1991

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CIVIL ACTION NO. 89-1716

EPISCOPAL HOSPITAL, ET. AL., PLAINTIFFS,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

NOVEMBER 12, 1991

ORDER AND JUDGMENT

Upon consideration of the motion of plaintiffs for summary judgment, the motion of defendant for summary judgment, the submissions of the parties, the record as a whole, and consistent with the accompanying Memorandum Opinion, it is this 12th day of November, 1991,

ORDERED that the motion of plaintiffs for summary judgment be, and hereby is, denied; and it is further

ORDERED that the motion of defendant for summary judgment be, and hereby is, granted; and it is further

ORDERED that judgment be, and hereby is, entered in favor of defendant.

/s/ NORMA HOLLOWAY JOHNSON

NORMA HOLLOWAY JOHNSON
UNITED STATES DISTRICT JUDGE

APPENDIX E

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

CIVIL ACTION NO. 91-1657 (NHJ)

EPISCOPAL HOSPITAL, ET AL., PLAINTIFFS,

v.

LOUIS SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

December 18, 1991

STIPULATED ORDER AND JUDGMENT

JOHNSON, District Judge.

Plaintiffs Episopal Hospital et al. ("Plaintiff-Hospitals") and Defendant, Louis W. Sullivan, M.D., Secretary of Health and Human Services (the "Secretary"), by and through their undersigned counsel, hereby agree and stipulate as follows:

WHEREAS in Civil Action No. 89-1716 (NHJ), Plaintiff-Hospitals challenged a refusal by the Secretary to adjust the hospital-specific portion of their Medicare prospective payment rates on appeals from determinations of the Provider Reimbursement Review Board ("PRRB") for their fiscal years ending 1985, 1986, and 1987.

WHEREAS Plaintiff-Hospitals filed Civil Action No. 91-1657 (NHJ) as a related action to No. 89-1716 raising the identical claims on appeal from the PRRB with respect to their fiscal year ending 1988.

WHEREAS at a status conference held on October 18, 1991 the Parties jointly requested the Court to stay further action in No. 91-1657 (NHJ) pending disposition of cross-motions for summary judgment in No. 89-1716, given the likelihood that the decision in the first case would be controlling.

WHEREAS the Court rendered a Memorandum Opinion and an Order and Judgment on November 12, 1991 granting summary judgment to the Secretary and denying summary judgment to Plaintiff-Hospitals.

WHEREAS the Court has noticed a status call in No. 91-1657 for December 13, 1991 and the parties wish to deal efficiently, economically and expeditiously with these cases.

WHEREFORE the parties hereby jointly agree to stipulate and request the Court to enter, as an Order and Final Judgment resolving No. 91-1657, the following:

1. The Memorandum Opinion and Order and Judgment filed on November 12, 1991 in No. 89-1716 shall be treated as dispositive of No. 91-1657, which involves the identical parties and the identical legal issues for a more recent fiscal year.

2. Judgment shall be entered for the Secretary and against the Plaintiff-Hospitals for the reasons supporting the Court's disposition of No. 89-1716, as set forth in the Court's Memorandum Opinion in No. 89-1716.

3. This Stipulation is not, nor is it intended by the Plaintiff-Hospitals as, a concession as to the merits of the Court's decision in No. 89-1716 or a waiver of the right to appeal in either case, which right to appeal is expressly reserved.

Respectfully submitted,

For the Plaintiffs Hospitals:

/s/ MARK H. GALLANT, ESQUIRE

Mark H. Gallant, Esquire
D.C. Bar No. 913111
WOLF, BLOCK, SCHORR
and SOLIS-COHEN
Twelfth Floor Packard Building
15th & Chestnut Streets
Philadelphia, PA 19102
(215) 977-2008

For the Secretary:

/s/ LINDA RUIZ, ESQUIRE

Linda Ruiz, Esquire
D.C. Bar No. 318386
Office of the General Counsel
DEPARTMENT OF
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SERVICES
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OF COUNSEL:

Robert C. Seldon, Esquire
D.C. Bar No. 245100
KROOTH & ALTMAN
2101 L Street, N.W.
Suite 210
Washington, D.C. 20037
(202) 293-8200

The foregoing Stipulation is hereby APPROVED, and it is hereby ORDERED that Judgment shall be entered for the Defendant and against the Plaintiffs.

December 18, 1991	/s/ NORMA HOLLOWAY JOHNSON
Dated	By: U.S.D.J.

APPENDIX F

PROVIDER REIMBURSEMENT REVIEW BOARD

CASE NO. 89-5037G

PHILADELPHIA HOSPITALS GROUP APPEAL

FYE JUNE 30, 1986 AND JUNE 30, 1987

May 8, 1990

BOARD DETERMINATION

Mark H. Gallant, Esquire
Wolf, Block, Schorr and Solis-Cohen
Twelfth Floor Packard Building
S.E. Corner 15th and Chestnut Streets
Philadelphia, PA 19102-2678

Dear Mr. Gallant:

Re: Philadelphia Hospitals Group Appeal, Case No. 89-5037G, FYE — June 30, 1986, and June 30, 1987, Request for A Board Determination that It Lacks the Authority to Decide Whether the Hospital Specific Rate Should Have Been Increased Throughout the PPS Transition Period to Account for the Base-Year Costs Incurred in Treating Beneficiaries After the Post-Admission Expiration of Their Medicare Coverage

This is in response to your request that the Provider Reimbursement Review Board (Board), pursuant to 42 USC 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the question of whether the hospital specific rate should have been increased throughout the PPS transition period to account for the base-year costs incurred for the above type of modification. The above-cited statutory provision permits a provider that requested and is entitled to a hearing before the Board,

under USC 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the Providers' submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $50,000 and is approximately $474,000 for FYE June 30, 1986, and $426,000 for FYE June 30, 1987. The estimated amount in controversy is subject to recalculation by the intermediary for the actual final amount.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject years and that the Providers are entitled to a hearing before the Board;
2. That based upon the Providers' assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulations (42 CFR 405.1867); and
4. That the Board is without authority to decide the legal question of whether the Medicare regulations governing the reimbursement for the above issue (42 CFR 412.71(b) and 412.71(c) are valid.

Accordingly, the Board finds that this case properly falls within 42 USC 1395oo(f)(1) and hereby grants the Providers' requests for expedited judicial review for the above stated issue for the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan

FOR THE BOARD:

/s/ Keith E. Braganza
Board Member

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended
Schedule of Participating Providers

cc: William Braggs, BC&BSA
Bernard Talbert, BC&BSA
Charles Knowlton, Aetna

APPENDIX G

PROVIDER REIMBURSEMENT REVIEW BOARD

CASE NO. 90-1920G
PHILADELPHIA HOSPITALS GROUP APPEAL
FYE JUNE 30, 1988

May 6, 1991

BOARD DETERMINATION

Mark H. Gallant, Esquire
Wolf, Block, Schorr and Solis-Cohen
Twelfth Floor Packard Building
S.E. Corner 15th and Chestnut Streets
Philadelphia, PA 19102-2678

Dear Mr. Gallant:

Re: Philadelphia Hospitals Group Appeal, Case No. 90-1920G, FYE — June 30, 1988, Request for A Board Determination that It Lacks the Authority to Decide Whether the Hospital Specific Rate Should Have Been Increased Throughout the PPS Transition Period to Account for the Base-Year Costs Incurred in Treating Beneficiaries After the Post-Admission Expiration of Their Medicare Coverage

This is in response to your request of April 22, 1991, that the Provider Reimbursement Review Board (Board), pursuant to 42 USC 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the question of whether the hospital specific rate should have been increased throughout the PPS transition period to account for the base-year costs incurred for the above type of modification. The above-cited statutory provision permits a provider that requested and is entitled to a hearing before the Board, under USC 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving

a question of law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the Providers' submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the providers on the enclosed schedule exceeds $50,000 and is approximately $237,000. The estimated amount in controversy is subject to recalculation by the intermediary for the actual final amount.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject year and that the Providers on the enclosed schedule are entitled to a hearing before the Board;
2. That based upon the Providers' assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulation (42 CFR 405.1867); and
4. That the Board is without authority to decide the legal question of whether the Medicare regulations governing the reimbursement for the above issue (42 CFR 412.71(b) and 412.71(c) are valid.

Accordingly, the Board finds that this case properly falls within 42 USC 1395oo(f)(1) and hereby grants the Providers' requests for expedited judicial review for the above stated issue for the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan
Juanita Petti-Hankins

FOR THE BOARD:

/s/ Keith E. Braganza
Board Member

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended
Schedule of Participating Providers

cc: BCBSA
Aetna

APPENDIX H

PROVIDER REIMBURSEMENT REVIEW BOARD

CASE NO. 87-5007G

PHILADELPHIA HOSPITALS GROUP APPEAL

FYE JUNE 30, 1985

April 12, 1989

BOARD DETERMINATION

Mark H. Gallant, Esquire
Wolf, Block, Schorr and Solis-Cohen
Twelfth Floor Package Building
S.E. Corner 15th and Chestnut Streets
Philadelphia, PA 19102-2678

Re: Philadelphia Hospitals Group Appeal, Case No. 87-5007G, FYE — June 30, 1985, Request for A Board Determination that It Lacks the Authority to Decide Whether the Hospital Specific Rate Should Have Been Increased Throughout the PPS Transition Period to Account for the Base-Year Costs Incurred in Treating Beneficiaries After the Post-Admission Expiration of Their Medicare Coverage

This is in response to your request that the Provider Reimbursement Review Board (Board), pursuant to 42 USC 1395oo(f)(1), as amended by the Omnibus Reconciliation Act of 1980 (Section 955 of Public Law 96-499), determine that it is without authority to decide the question of whether the hospital specific rate should have been increased throughout the PPS transition period to account for the base-year costs incurred for the above type of modification. The above-cited statutory provision permits a provider that requested and is entitled to a hearing before the Board, under USC 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of

law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the Providers' submissions pertaining to the request for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy exceeds $50,000 and is approximately $700,000. The estimated amount in controversy is subject to recalculation by the intermediary for the actual final amount.

The Board finds:

1. That the Board has jurisdiction of the matter for the subject year and that the Providers are entitled to a hearing before the Board;
2. That based upon the Providers' assertions, there are no findings of fact for resolution before the Board;
3. That the Board is bound by the applicable existing Medicare law and regulations (42 CFR 405.1867); and
4. That the Board is without authority to decide the legal question of whether the Medicare regulations governing the reimbursement for the above issue (42 CFR 412.71(b) and 412.71(c)) are valid.

Accordingly, the Board finds that this case properly falls within 42 USC 1395oo(f)(1) and hereby grants the Providers' requests for expedited judicial review for the above stated issue for the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

/s/ Arthur P. Owens
Acting Chairman

Enclosure
Section 1878(f)(1) of the Social Security Act, as amended
Schedule of Participating Providers

cc: Michael Harty, BC&BSA
Bernard Talbert, BC&BSA
Charles Knowlton, Aetna

APPENDIX I

STATUTORY PROVISIONS

§ 1395ww. Payments to hospitals for inpatient hospital services

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this subchapter with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause (ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning —

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this subchapter.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital —

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B) of this section).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account —

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which —

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on September 3, 1982.

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are

determined on an average per admission or per discharge basis (as determined by the Secretary). Such term does not include costs of approved educational activities, a return on equity capital, or, other capital-related costs (as defined by the Secretary for periods before October 1, 1987).

(b) Computation of payment; definitions; exemptions; adjustments

(1) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, if the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) of this section) for a cost reporting period subject to this paragraph —

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus —

(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 5 percent of the target amount,

whichever is less; or

(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under part A of this subchapter on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

except that in no case may the amount payable under this subchapter (other than on the basis of a DRG prospective payment rate determined under subsection (d) of this section) with respect

to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a) of this section.

(2) Repealed. Pub.L. 98-21, Title VI, § 601(b)(4), Apr. 20, 1983, 97 Stat. 150

(3)(A) Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period —

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

* * * * * * * * * * * * * *

(4)(A) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception,

or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hosptial of providing inpatient services, the Secretary shall take into consideration —

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1395f(b) of this title.

* * * * * * * * * * * * * *

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographic Classification Review Board

(1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year —

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of —

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period

(as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of —

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section), and

(II) the DRG percentage (as defined in subparagraph (c)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, and ending on September 30, 1993, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than —

(i) a psychiatric hospital (as defined in section 1395x(f) of this title),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominately individuals under 18 years of age,

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or

(v) a hospital that the Secretary has classified, at any time on or before December 31, 1991,[1] (or, in the case of a hospital that, as of December 19, 1989, is located in a State operating a demonstration project under section 1395f(b) of this title, on

or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary).

(C) For purposes of this subsection, for cost reporting periods beginning —

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring —

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(5)(A)(i) The Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days,

or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG perospective payment rate, or exceed such other fixed dollar amount, whichever is greater.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

* * * * * * * * * * * * * *

(E)(i) The Secretary shall estimate the amount of reimbursement made for services described in section 1395y(a)(14) of this title with respect to which payment was made under part B of this subchapter in the base reportng periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

* * * * * * * * * * * * * *

(I) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

APPENDIX J

REGULATIONS

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42 C.F.R. § 412.2

§ 412.2 Basis of payment.

* * * * * * * * * * * * * *

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph (b)(2), include the following:

(i) Waiver of liability days payable under § 405.330 of this chapter.

(ii) Guarantee of payment days, as authorized under § 409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

42 C.F.R. § 412.70

§ 412.70 General description.

(a) *Basic rules.* (1) During the initial four-year transition period, payments to all hospitals paid under the prospective payment system are based on a combination of the Federal prospective payment rates, as determined under subpart D of this part, and hospital-specific rates determined under this subpart.

(2) For the first two years of the transition period, both portions of the payment rates are also adjusted to ensure budget neutrality.

(3) At the end of the transition period (that is, for cost reporting periods beginning on or after October 1, 1987), payments are based on the national prospective payment rates determined under supbart D of this part, except for payments that may be made under the special treatment provisions of subpart G of this part.

(b) *Payment amounts based on the hospital-specific portion and the Federal portion.* For discharges occurring in cost reporting periods beginning on or after October 1, 1983 and before October 1, 1987, the Medicare transition payment rate for a particular covered discharge equals a blend of the applicable portion of the hospital-specific rate, as determined under § 412.73, plus the applicable portions of the Federal national and regional prospective payment rates, as described in paragraph (c) of this section, and summarized in the Table. Payments to new hospitals are based on the Federal national and regional prospective payment rates, as described in paragraph (d) of this section.

(c) *Amount of blended portions.*[1] The blends of hospital-specific and Federal portions are as follows:

(1) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the blend is —

(i) 75 percent of the hospital-specific rate; and

(ii) 25 percent of the appropriate Federal prospective payment rate.

(2) For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, the blend is —

(i) 50 percent of the hospital-specific rate; and

(ii) 50 percent of the appropriate Federal prospective payment rate.

(3) For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the blend is as follows:

(i) For the first seven months of the cost reporting period, the blend is —

(A) 50 percent of the hospital-specific rate; and

(B) 50 percent of the appropriate Federal prospective payment rate.

(ii) For the remaining five months of the cost reporting period, the blend is —

(A) 45 percent of the hospital-specific rate; and

(B) 55 percent of the appropriate Federal prospective payment rate.

(4) For cost reporting periods beginning on or after October 1, 1986 and before October 1, 1987, the blend is —

(i) 25 percent of the hospital-specific rate; and

(ii) 75 percent of the appropriate Federal prospective payment rate.

(5) The appropriate Federal prospective payment rate is a combined regional and national rate and changes with the Federal fiscal year. For Federal fiscal year 1984, which begins October 1, 1983, the Federal prospective payment rate is 100 percent regional. For Federal fiscal years 1985 and 1986, which begin October 1, 1984 and October 1, 1985, respectively, the combined rate is 75 percent regional and 25 percent national. For Federal fiscal year 1987, which begins October 1, 1986, the combined rate is 50 percent regional and 50 percent national. Effective with Federal fiscal year 1988, which begins October 1, 1987, the Federal prospective payment rate is 100 percent national except as provided in paragraph (c)(6) of this section.

(6) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standarized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

TABLE — SUMMARY OF HOSPITAL-SPECIFIC AND FEDERAL PORTION PERCENTAGES FOR DETERMINING TRANSITION PAYMENT RATES

Cost reporting period beginning on or after	Hospital-specific portion percentage	Federal portion percentage*
October 1, 1983	75	25
October 1, 1984	50	50
October 1, 1985 —		
The first seven months of the cost reporting period	50	50
The remaining five months of the cost reporting period	45	55
October 1, 1986	25	75
October 1, 1987	0	100

* NOTE: The Federal portion percentages are applied to the combined national or regional prospective payment rates, as appropriate, as determined under Subpart D of this part for the Federal fiscal year in which discharge occurs.

(d) *Blended portions for new hospitals.* The prospective payment rates for new hospitals are a blend of the Federal regional and national rates as follows:

(1) For discharges occurring on or after October 1, 1983, and before October 1, 1984, the prospective payment rate equals the appropriate Federal regional rate.

(2) For discharges occurring on or after October 1, 1984 and before October 1, 1986, the prospective payment rate is a blend of —

(i) 75 percent of the appropriate Federal regional prospective payment rate; and

(ii) 25 percent of the appropriate Federal national rate.

(3) For discharges occurring on or after October 1, 1986 and before October 1, 1987, the prospective payment rate is a blend of —

(i) 50 percent of the appropriate Federal regional prospective payment rate; and

(ii) 50 percent of the appropriate Federal national prospective payment rate.

(4) For discharges occurring on or after October 1, 1987, the prospective payment rate equals the appropriate Federal national rate except as provided in paragraph (d)(5) of this section.

(5) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

[51 FR 16786, May 6, 1986, as amended at 53 FR 38528, Sept. 30, 1988]

42 C.F.R. § 412.71

§ 412.71 Determination of base-year costs.

(a) *Base-year costs.* (1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(2) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in § 412.74.)

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs as described in § 413.55 of this chapter, and exclude the following:

(1) Nursing differential costs as described in § 405.430[1] of this chapter.

(2) Medical education costs as described in § 413.85 of this chapter.

(3) Capital-related costs are described in § 413.130 of this chapter.

(4) Kidney acquisition costs incurred by hospitals approved as renal transplantation centers as described in § 412.100. Kidney acquisition costs in the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.

(5) Higher costs that were incurred for purposes of increasing base-year costs.

(6) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

(7) Higher costs that result from changes in hospital accounting principles initiated in the base year.

(8) For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, the cost of qualified nonphysician anesthetists' services as described in § 412.113(c).

(c) *Hospital's request for adjustment of base-year costs.* (1) Before the date it becomes subject to the prospective payment system, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

(i) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base-year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 405.550(b) of this chapter, and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m) of this chapter), but may not include the costs of anesthetists' services for which a physician employer continues to bill under § 405.553(b)(4) of this chapter.

(ii) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(2) If a hospital requests that its base-period costs be adjusted under paragraph (c)(1) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment, and adequate data to compute the adjusted costs. The

intermediary will decide whether to use part or all of the data on the basis of audit, survey and other information available.

(d) *Intermediary's determination.* The intermediary will use the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987]

42 C.F.R. § 412.72

§ 412.72 Modification of base-year costs.

(a) *Bases for modification of base-year costs.* Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

(1) *Inadvertent omissions.* (i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to reestimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(ii) The intermediary may also initiate changes to the estimation —

(A) For any reason before the date the hospital becomes subject to prospective payment; and

(B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(iii) Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education costs of approved educational activities and to adjustments specified in § 412.71(c).

(iv) The intermediary must notify the provider of any change to the hospital-specific amount as a result of the provider's request within 30 days of receipt of the additional data.

(v) Any change to base-period costs made under this paragraph (a)(1) will be made effective retroactively, beginning with the first day of the affected hospital's fiscal year.

(2) *Correction of mathematical errors of calculations.* (i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payment rates.

(ii) The intermediary may also identify such errors and initiate their correction during this period.

(iii) The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error.

(iv) Corrections of errors of calculation will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(3) *Recognition of additional costs.* (i) The intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

(A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(D) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(ii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base-year costs to take into account these additional costs —

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision; and

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

(4) *Successful appeal.* The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under § 412.71(b). If a hospital successfully contests a modification to base-year costs —

(i) The intermediary will recalculate the hospital's base-year costs to reflect the modification determined appropriate as a result of the appeal; and

(ii) Such adjustments will be effective retroactively to the time of the intermediary's initial estimation of base-year costs.

(5) *Unlawfully claimed costs.* The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgment under the False Claims Act (31 U.S.C. 3729-3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base-year costs, HCFA will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed on the basis of the final resolution of the amount of the inappropriate base-year costs.

(b) *Right to administrative and judicial review.* (1) An intermediary's estimation of a hospital's base-year costs, and modifications, made for purposes of determining the hospital-specific rate, are subject to administrative and judicial review. Review will be available to a hospital upon receipt of its notice of amount of program reimbursement following the close of its cost reporting period, but only with respect to whether the intermediary followed the provisions of §§ 412.71 and 412.72. (Sections 405.1803 and 405.1807 of this chapter set forth the rules for intermediary

determinations and notice of amount of program reimbursement and the effect of those determinations.)

(2) In any administrative or judicial review of whether the intermediary used the best data available at the time, as required by § 412.71(d), an intermediary's estimation will be revised on the basis of this review only if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made.

(3) Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation.

42 C.F.R. § 412.73(a)

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

(a) *Costs on a per discharge basis.* The intermediary will determine the hospital's estimated adjusted base-year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.